Benefits, Value Added Services and Premiums are effective January 1, 2013 through December 31, 2013

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	Network Providers
Combined In and Out of Network Deductible (Plan Level/includes Network Deductible)	$200

Unless otherwise indicated, the Deductible must be met prior to benefits being payable.

In-network services exempt from Deductible: Emergency Room Ambulance, Non-Emergency Room Ambulance, Emergency Room including foreign travel, Urgently Needed Care, Diabetic Supplies, Blood, Dialysis, Part B Drugs, Routine Hearing Exams, Routine Eye Exams, and all Medicare-Covered Preventive Services.

Deductible is NOT applicable to Hearing Aid Reimbursement, Vision Reimbursement and Medicare prescription drug coverage that may be available on your plan.

Member Coinsurance Applies to all expenses unless otherwise stated.	N/A
Annual Maximum Out-of-Pocket Amount (includes deductible)	$3,400
Combined Annual Maximum Out-of-Pocket Amount (Plan Level / includes deductible)	N/A

Annual Maximum Out-of-pocket Limit amount applies to all medical expenses. Part D prescription drug deductibles and copays do not apply to the plan out of pocket maximum.

Primary Care Physician Selection - Lower Primary Care Physicians cost share applies when care is received by a general practitioner,family practitioner or internist.	Optional

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Certification Requirements

There is not a requirement for member pre-certification. If a member fails to obtain pre-certification they will not be denied services or will any penalty amount be applied. However, pre-certification is requested by the Aetna provider on certain services including inpatient hospital care, inpatient mental health and substance abuse, skilled nursing facility, home health care and some durable medical equipment.

Referral Requirement	None
PREVENTIVE CARE	
"Welcome to Medicare" physical exam	Covered 100%; Deductible does not apply
Annual Wellness Exams One exam every 12 months	Covered 100%; Deductible does not apply
Medicare Covered Immunizations Pneumococcal, Flu, Hepatitis B	Covered 100%; Deductible does not apply
Routine GYN Care **(Cervical and Vaginal Cancer Screenings)** One routine GYN visit and pap smear every 12 months	Covered 100%; Deductible does not apply
Routine Mammograms (Breast Cancer Screening) One baseline mammogram for members 35-39; and one annual mammogram for members age 40 and over	Covered 100%; Deductible does not apply
Routine Prostate Cancer Screening Exam For covered males age 50 and over every 12 months	Covered 100%; Deductible does not apply
Routine Colorectal Cancer Screening For all members age 50 and over.	Covered 100%; Deductible does not apply
Routine Bone Mass Measurement One exam every 24 months	Covered 100%; Deductible does not apply
Additional Medicare Preventive Services***	Covered 100%; Deductible does not apply
Routine Hearing Screening One annual exam	Covered 100%; Deductible does not apply
PHYSICIAN SERVICES	
Primary Care Physician Visits	Covered 100%; Deductible Applies
Primary Care Physician Visits (after hours) Includes services of an internist, general physician, family practitioner.	Covered 100%; Deductible Applies
Physician Specialist Visits	$20 Copay; Deductible Applies
Allergy Testing/Treatment	Covered 100%; Deductible Applies
DIAGNOSTIC PROCEDURES	

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Outpatient Diagnostic Tests and Therapeutic Services and Supplies	Covered 100% for each Medicare-covered X-ray visit and/or simple diagnostic test Deductible applies. 100% coverage for each Medicare-covered complex diagnostic test and/or radiology visit Deductible applies. Covered 100% for each Medicare-covered radiation therapy treatment Deductible applies. Covered 100% for Medicare-covered supplies Deductible applies. Covered 100% for each Medicare-covered clinical/diagnostic lab test Deductible applies. Covered 100% per Medicare-covered pint of blood Deductible does not apply.
EMERGENCY MEDICAL CARE	
Urgently Needed Care	$20 Copay Deductible does not apply
Emergency Care; Worldwide (waived if immediately admitted to the inpatient facility)	$65 Copay; Deductible does not apply

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Ambulance Services	Covered 100%; Deductible does not apply
HOSPITAL CARE	
Inpatient Hospital Care	Covered 100%; Deductible Applies
Outpatient Surgery	Covered 100% for a visit to a network primary care physician in an outpatient hospital setting/clinic for Medicare-covered non-surgical services. Deductible Applies. $20 Copay for a visit to a network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services. Deductible applies.

The member cost sharing applies to covered benefits incurred during a member's outpatient visit. Cost sharing will be based upon the type of service received (consultations, test/ labs/ radiology) and the highest copayment will apply.

MENTAL HEALTH SERVICES	
Inpatient Mental Health Care	Covered 100%; Deductible Applies

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

Outpatient Mental Health Care	Covered 100%; Deductible Applies
ALCOHOL/DRUG ABUSE SERVICES	
Inpatient Substance Abuse (Detox and Rehab)	Covered 100%; Deductible Applies

The member cost sharing applies to covered benefits incurred during a member's inpatient stay

Outpatient Substance Abuse (Detox and Rehab); Including Partial Hospitalization	Covered 100%; Deductible Applies

The member cost sharing applies to covered benefits incurred during a member's outpatient visit.

OTHER SERVICES	
Skilled Nursing Facility (SNF) Care	Covered 100%; Deductible Applies

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Limited to 100 days per Medicare benefit period.
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

Home Health Agency Care	Covered 100%; Deductible Applies
Hospice Care	Covered by Medicare at a Medicare certified hospice $20 Copay for consultation; Deductible does not apply
Outpatient Rehabilitation Services	$20 Copay; Deductible Applies

Covered Services: Speech, Physical, and Occupational therapy.

Cardiac Rehabilitation Services	$20 Copay; Deductible Applies
Pulmonary Rehabilitation Services	$20 Copay; Deductible Applies
Chiropractic Services	$20 Copay; Deductible Applies

For manipulation of the spine to the extent covered by Medicare

Non-Medicare Covered Chiropractic Services	20% Coinsurance; Deductible Applies

Benefits are provided for ancillary treatment such as massage therapy, heat and electro-stimulation provided by a licensed chiropractor in conjunction with an active course of treatment.

Durable Medical Equipment - includes wigs and compression stockings	Covered 100%; Deductible Applies
Prosthetic Devices	Covered 100%; Deductible Applies
Podiatry Services	$20 Copay; Deductible Applies

In addition to Medicare covered services, plan will cover routine service for the removal of corns and calluses.

Diabetic Supplies	Covered 100%; Deductible does not apply

Covered services include:Blood glucose monitor, blood glucose test strips, urine test strips, lancet.

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Outpatient Dialysis Treatments	Covered 100% for each Medicare-covered kidney education session. Deductible applies. Covered 100% for Medicare-covered outpatient or physician office dialysis. Deductible does not apply. Covered 100% for Medicare-covered home dialysis or home support services. Deductible does not apply. Covered 100% for Medicare-covered self-dialysis training. Deductible does not apply. Covered 100% for Medicare-covered home dialysis equipment and supplies. Deductible applies

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Medical nutrition therapy	Covered 100%
Medicare Part B Prescription Drugs	Covered 100%
Medicare Covered Dental Coverage for Medicare Covered Benefits Only.	$20 copay; Deductible Applies
Vision Care	Covered 100% for visits to a network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye. Deductible applies. $20 copay for visits to a network specialist for Medicare-covered exams to diagnose and treat diseases of the eye. Deductible applies. Covered 100% for Medicare-covered glaucoma screening. Deductible does not apply. Covered 100% for glasses/contacts following Medicare covered cataract surgery. Deductible applies.
Temporomandibular Joint Syndrome (TMJ)	20% Coinsurance; Deductible Applies

Coverage is provided for the treatment of a specific organic condition of or physical trauma to the temporomandibular joint (jaw hinge). Coverage is limited to surgery or injections of the temporomandibular joint, physical therapy, or other medical treatments Benefits are not provided for any temporomandibular joint syndrome services not listed as covered in the Covered Services section. Coverage is not provided for any procedure or device that alters the vertical relationship of the teeth or the relation of the mandible to the maxilla. Dental services related to TMJ are not covered.

Hearing Aid Reimbursement	Discounts where available
Coaching One phone call per week	Included
Acupuncture	Discounts where available
Fitness Membership	Silver & Fit

PHARMACY - PRESCRIPTION DRUG BENEFITS	**Cost Share**
Prescription drug calendar year deductible	$0

Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible.

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Initial Coverage Limit (ICL)	$2,970	Covered Medicare Prescription Drug Expenditure

The Initial Coverage Limit includes the applicable plan deductible. Until covered Medicare Prescription Drug expenses reach the Initial Coverage Limit (and after the deductible is satisfied), cost-sharing is as follows:

Retail - Member Cost-Sharing up to the Initial Coverage Limit	Member pays $10 Copay for Tier 1 Generics $0 Copay for Select Generics Member pays $30 Copay for Tier 2 Preferred Brand Member pays $45 Copay for Tier 3 Non-Preferred Brand

Up to one month (31 day) supply at indicated copay or coinsurance
Three month (90 day) supply available at retail. Dollar copayments or applicable coinsurance will apply for each month supply.

Mail Order through Aetna Rx Home Delivery - Member Cost-Sharing up to Initial Coverage Limit	Member pays $10 Copay for Tier 1 Generics $0 Copay for Select Generics Member pays $30 Copay for Tier 2 Preferred Brand Member pays $45 Copay for Tier 3 Non-Preferred Brand

Up to a three month (90 day) supply available via our preferred vendor, Aetna Rx Home Delivery.

Coverage Gap*

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Once covered Medicare Prescription Drug expenses have reached the Initial Coverage Limit, the Coverage Gap begins. Member cost sharing under the plan between the Initial Coverage Limit and until $4,750 in true out-of-pocket costs for Covered Part D drugs is incurred is as follows:

Retail - Member Cost-Sharing during Coverage Gap*	Member pays $10 Copay for Tier 1 Generics $0 Copay for Select Generics Member pays $30 Copay for Tier 2 Preferred Brand Member pays $45 Copay for Tier 3 Non-Preferred Brand

Up to one month (31 day) supply at indicated copay or coinsurance
Three month (90 day) supply available at retail. Dollar copayments or applicable coinsurance will apply for each month supply.

Mail Order through Aetna Rx Home Delivery - Member Cost Sharing during Coverage Gap*	Member pays $10 Copay for Tier 1 Generics $0 Copay for Select Generics Member pays $30 Copay for Tier 2 Preferred Brand Member pays $45 Copay for Tier 3 Non-Preferred Brand

Up to a three month (90 day) supply available via our preferred vendor, Aetna Rx Home Delivery.

Catastrophic Coverage	Member pays $0 once $4,750 in true out-of-pocket is incurred.

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Requirements:	
Precertification	Yes
Step-Therapy	Yes
Formulary	Custom (Three Tier)